

# Benefit Highlights

## AARP® Medicare Advantage Patriot No Rx NC-MA02 (HMO-POS)

This is a short description of your 2024 plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

Plan costs	
Monthly plan premium	\$0
Part B Premium Reduction	Up to \$100
Medical benefits	
Annual Medical Deductible	No deductible
Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)	\$6,900
Doctor's office visit	
Primary care provider (PCP)	\$0 copay
Specialist	\$40 copay (no referral needed)
Virtual visits	\$0 copay to talk with a network telehealth provider online through live audio and video
Preventive services	\$0 copay
Inpatient hospital care	\$375 copay per day: days 1-6 \$0 copay per day: days 7 and beyond
Skilled nursing facility (SNF)	\$0 copay per day: days 1-20 \$203 copay per day: days 21-100
Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)	\$375 copay
Outpatient mental health	
Group therapy	\$15 copay
Individual therapy	\$25 copay

## Medical benefits

Virtual visits	\$0 copay to talk with a network telehealth provider online through live audio and video
Diabetes monitoring supplies	\$0 copay for covered brands
Diagnostic radiology services (such as MRIs, CT scans)	\$225 copay
Diagnostic tests and procedures (non-radiological)	\$45 copay
Lab services	\$0 copay
Outpatient x-rays	\$25 copay
Ambulance	\$290 copay for ground or air
Emergency care	\$100 copay (\$0 copay for emergency care outside the United States) per visit
Urgently needed services	\$40 copay (\$0 copay for urgently needed services outside the United States) per visit

## Benefits and services beyond Original Medicare

Routine physical	\$0 copay, 1 per year
Routine eye exams	\$0 copay, 1 per year
Routine eyewear	<p>\$0 copay Plan pays up to \$300 every year toward your purchase of frames (with standard lenses covered in full) or contact lenses (fitting and evaluation may be an additional cost) through UnitedHealthcare Vision.</p> <p>Home delivered eyewear available through UnitedHealthcare Vision (select products only). You are responsible for all eyewear costs from providers outside of the UnitedHealthcare Vision network.</p>
Dental - preventive (covered in-network and out-of-network)	\$0 copay for exams, cleanings, X-rays, and fluoride*
Dental - comprehensive (covered in-network and out-of-network)	50% coinsurance on dentures and bridges \$0 copay for all other covered comprehensive services*

## Benefits and services beyond Original Medicare

<b>Dental - benefit limit</b>	\$2,000 combined limit on all covered dental services* If you choose to see an out-of-network dentist you might be billed more, even for services listed as \$0 copay
<b>Hearing - routine exam</b>	\$0 copay, 1 per year
<b>Hearing aids</b>	\$99 to \$1,249 copay for each hearing aid through UnitedHealthcare Hearing, up to 2 hearing aids every year.  Includes hearing aids delivered directly to you with virtual follow-up care (select models).
<b>Fitness program</b>	\$0 copay for Renew Active®, which includes a free gym membership, plus online fitness classes and brain health content.
<b>Personal emergency response system</b>	\$0 copay for a personal emergency response system (PERS)
<b>Foot care - routine</b>	\$40 copay, 6 visits per year
<b>Over-the-counter (OTC) credit</b>	\$40 credit every quarter to buy covered OTC products
<b>Meal benefit</b>	\$0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay.
<b>Nurse Hotline</b>	Speak with a registered nurse (RN) 24 hours a day, 7 days a week.

\*Benefits are combined in and out-of-network



This information is not a complete description of benefits. Contact the plan for more information.

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